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ABSTRACT

The child is scapegoat in the struggle between varying forces--political, professional, or ideological--in the effort to establish services on his behalf. Faddism, political mottoes, and professional cliches are overdetermining service planning for children. The child has become the victim of his rescuers. Illustrations are given from national and state levels concerning current conflicts regarding day care, the juvenile justice system, and judicial determination for voluntery placements. Also discussed are oriented social services and community control issues. (Author)

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THE CHILD AS VICTIM

A SYSTEM OF PARADOXES

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If we had paid no more attention to our plants than we have to our children, we would now be living in a jungle of weeds.

Luther Burbank

A case history demonstrates swiftly how easily a child we seek to help can be victimized instead. A young babysitter was so disturbed by what a 12-year-old girl told her about her stepfather that the babysitter, appalled, turned to her priest.

Her good intentions led to the first act in a series that may, paradoxically, have made the child's situation worse than it was before.

What the girl had told her was that she had been forced into sexual relations over the past four years by her stepfather. The priest approached the family and urged them to consult a family guidance agency. When the girl and her mother were seen, it was learned that under the threat of being killed by the stepfather, she had engaged in fellatio, and masturbated the father. The mother revealed that while she suspected something was going on, she did not know it was this serious, and expressed concern about not wanting to lose her otherwise "happy" marriage.

Further discussion revealed that a second child -- a six-year-old son and product of their union -- was being enticed with anal intercourse by the father and that these two older children were inserting objects into the anus of the third, a four-year-old child.

The case became even more complicated when it turned out that the family's legal counselor was involved sexually with both parents. Further complications occurred when the mother accused the referring priest, stating that he had made homosexual advances to the youngest son.

After all the efforts of the agency on behalf of the oldest child to disengage her from this unhealthy involvement and to restore some sense of dignity and self-worth to the children, as well as to help the father, all came undone in the legal tangle brought about by the legal requirements of the newly adopted child abuse reporting system in the State of New York.

According to the regulations, the private agency was obligated to report the case. And this is where the real trouble started. For the child abuse section of the public agency did not really want to handle the sexual

complexities of this case -- their metier was, after all, physical, not psychological abuse. Now, if the father had struck the daughter they would have been better prepared to do something.

In the course of the required investigation and court procedures, the family closed ranks. The child was discredited as a tattle-tale with everyone pretending, on legal advice apparently, that this was fiction. As a consequence, the child ended up being in a much more dangerous predicament and in greater sexual bondage than before the agency tried to help. The clinic lost its leverage in promoting a change within the family. This situation arose from the development of a law that was supposed to serve the child. But, by virtue of rigid reporting requirements, the law served mainly to alienate the child and the family from the sources of aid.

The whole case is a paradigm for the mental health road, that is paved with good intentions but may lead to a paradoxical denouement.

In the United States, we write, talk, discuss, and confer at length about the needs of the children -- their

health and welfare, their academic achievements and their school failures, their civil rights and their civil liberties. Children, we acknoweldge, are our most important human resource and we accept our responsibility to rear them to mature, productive adulthood. We establish commissions, set up conferences, conduct studies, and issue reports with great regularity. We even follow up on the endless studies, reports, and recommendations. And, then, for reasons that are essentially unrelated to the needs of children, as we shall demonstrate, we take off, in a great flurry of self-righteousness and self-satisfaction, on a course of action that only negates our efforts and compounds the problems. We continue to subscribe, of course, to the myth that ours is a child-centered society and maintain a virtuous stance of commitment to the welfare of children, when, in fact, the American society does so little to support our view. A youth-oriented culture and a society that cares for its young are not one and the same thing.

Slide 1, 2, 3, 4, 5

The poverty of our efforts is in inverse proportion to the abundance of our stated intentions: witness the

large numbers of children who languish in state hospitals and discredited training schools without care or treatment; the miniscule portion of mental health funds allocated for children's services; the series of legislative actions designed presumably to protect the welfare of children, but which tear down the bulwark of established and proved services.

These seem to us to demonstrate that, although we care, we end up being basically punitive and uncaring, that we would rather punish than help the defenseless, voiceless, and impotent victims of our social ills. We may recoil with horror from the barbaric practice of so-called primitive cultures that abandon the defective or let the useless and unwanted die. Yet, does our society care for the emotionally ill, the socially delinquent, the mentally retarded, the child without a family? Is ours not a modern counterpart of barbaric ancient practice?

We are all of us aware of the numerous studies, up to and including the impressive report of the Joint Commission[1] on the Mental Health of Children, the many White House Conferences that produced no action, and now the Children's Bill of Rights[2], all part of an ongoing talkfest about children.

And we can only conclude that we are ambivalert, to put it kindly, about making the social and fiscal investment that would save our victimized children.

We could go further: As mental health professionals, we deal frequently with the phenomenon of countertransference in the treatment of the most severely ill patients, whose very helplessness and hopelessness may trigger rage, frustration, and even destructiveness within us, the supposed therapeutic agents.

Perhaps we do not really sympathize with weakness and helplessness and are therefore punitive, rather than caring toward the weak and helpless. Is our aggression provoked as a defense against our own fears of being helpless or weak? There seems no other explanation of this system of paradoxes, this affluent, technologically advanced, and politically sophisticated society that persists in victimizing its children.

WELL-INTENTIONED LEGISLATION

Understanding legislative hostility may explain recent trends in child welfare legislation and why they currently serve to vitiate good existing programs. Funding

requirements, for example, are such as to stigmatize the children and set up obstacles to sound care. Yet, by failing to provide good quality care for the hapless children, we punish them for the "sins" of their equally hapless parents, who may be poor, ill, weak, or Black. Perhaps it is not so much the children we hate as their helpless, neglectful, and abusive parents. Recently, when comprehensive legislation[3] was proposed that would have made good day care services available to all children -- much like Russia has had for decades -- a hue and cry went up about shifting responsibility for child rearing from the parents to the state. The legislation was vetoed. One wonders whether this insistence that the family is invariably responsible for child care is not another way of saying to the children: If you do not have good parents, you are not entitled to good alternate forms of care.

What we are describing is in painful contrast to the warm and tender care extended to all children in some other nations and societies, both democratic and authoritarian. Bronfenbrenner[4] in his Two Worlds of Childhood generally describes that the Russians practice what we in the U.S.A. preach about child care. In the Soviet Union and the People's

Republic of China the concept of universality of early childhood care is a fundamental precept of governments carrying out the State's commitment to children. Infant creches, prenursery centers, and day care facilities all reflect loving care and nurture. Trained child care personnel are accorded high social status and professional respect in their child rearing and guidance role. In Israel, Australia, and the Scandinavian countries, all of whom provide certain basic kinds of care for children under government auspices, it is accepted that many young children will require supplementary or substitute care of an extent and quality equal to, and perhaps in some instances better than, that which might be provided by the natural parents. These societies recognize the welfare of children as a fundamental responsibility. Our day care seems mainly to be in the service of getting and keeping mothers off welfare.

CONFOUNDING JUVENILE JUSTICE

The following legislation illuminates our ambivalence, our do-goodism that leads to bad laws, or should we say good laws that lead to unanticipated negative effects.

Let us examine how one of the recent Federal laws,

chapter 996 of the laws of 1973, Sections 358a to b and 398a[5] has altered what should be a treatment procedure into a legal conflict, an adversary procedure. And this law was enacted, not as avowed, to benefit the child, but to find a way to replenish the public purse vis-a-vis State reimbursement by the Federal government.

The law requires a judicial determination for the voluntary placement of children outside of the home. This was done because of a real concern that some children were being tracked into placement involuntarily and unfairly, possibly through the cooperation and/or collusion of parents and agencies. On the face of it, this legal procedure is reasonable: It assures the protection of a child's civil liberties and avoids undue haste about future decisions. Regretfully, this road of good intentions is paved with rhetoric, not reality. Even under the old system court calendars were crowded and the process was painfully slow as judges acted on the advice of child care specialists. But what has the new 1973 law set up? Delays that could run into months and, in some instances, years. Instead of working out a treatment goal that would help the child and the family, we have antagonists confronting one another in an adversary proceeding between parent and child.

What was the advantage of the old way? A family consulted a voluntary agency about the placement of a child. Often there was no such need, sometimes it was worked out between the family and the agency and even gladly accepted by the child. When placement was decided on by all concerned, a procedure was followed to obtain funding for eligible families via the Department of Social Services or families could apply directly to Departments of Social Service for this help. For the State to apply to receive Federal reimbursement, a judicial determination must first have taken place. Needless to say, and for obvious reasons, then, it is judicial determination that takes center stage, not the welfare of the child in question.

The original goal of the family court, whatever its shortcomings, was basically social. In the press for civil liberties and civil rights that concept seems to have given way to a purely legal instrument that operates on rules of evidence as if the child were some sort of adult offender. Ostensibly designed to protect the child, the way the new law has been applied has another drawback: It tends to reduce the options available to the child and the family. Thus, we make further progress and achieve another advance on behalf of children who are enmeshed in the juvenile justice

system that by general agreement is a scandal in its inequity and ineffectiveness. Within this system the child is apprehended: the court hears, studies, adjudicates, and makes final disposition, with limited resources in terms of staff and services. Except in rare cases, it has never been able to offer the social intervention and appropriate treatment that the child really needs. In the name of child advocacy, we have taken a step backward. By setting up the court appearance of the child as an adversary procedure, we inspire more fear than comfort in the juvenile and his parents.

Furthermore, in New York City, Law Guardians have been assigned to represent each child in order to protect his civil liberties. But this does not heal his psyche. Because the training schools have been discredited -- and with this we would not argue -- the judges are reluctant to send children, there, and so often they are sent home. We have gained little by the new 1973 law. What we have failed to achieve are appropriate alternatives, and as a result there are large numbers of very sick, very disturbed, and very dangerous children on the streets, with the official sanction

of the court. The government worries that the reform of the institutional system will be too costly. The professionals worry that the institutional system is backward and counter-productive. No one worries that there is little support for alternative means to help the children.

HORRENDOUS HOSPITALS

If the children are ill-served by the law, it would appear that they are not much better served by the hospital system.

Throughout the country, press reports recount the new revolving door policy for adults of the great state hospital systems[6] -- in for 30 days, 60 days, perhaps 90 days, and out again into the community. The revolving door policy, of course, signifies a statistical not a treatment achievement for the hospital. And, it certainly does not assure that the discharged patient has been equipped to cope with the community to which he is being returned.

In the case of children, some state commissioners of mental health assumed the official or could it be professional stand that no child belongs in a hospital. We take issue with that statement. But certainly, no child belongs in a bad hospital and no child belongs in a hospital

without adequate treatment services. What concerns us is whether such a decision is related more to saving money than to saving children.

The fact is that the state hospitals, by and large, have failed to develop appropriate services to meet the special needs of children.

Many aggressive adolescents are refused admission to state hospitals because they are declared non-psychotic. Nevertheless, they may be extraordinarily sick children for whom no other services are available. They are not less severely ill because their illness takes the form of aggressive, delinquent, and anti-social behavior, or because they are not quite old enough to be adjudged psychotic and therefore in need of hospitalization. Appropriate services for this age group have not been developed. Meanwhile, diagnostic classifications appear to be utilized to exclude them from care. The child is victimized by professional and ideological conflict, and, paradoxically, psychiatric judgment is used to deny him service.

Again, the heart of the matter seems to be

economic, rather than professional. For example, a report of the New York State Legislative Commission on Expenditure Review[7] offered a program audit that demonstrated how the costs of care escalate as the child moves from community services to institutional treatment and into the State systems. Thus, per annum, community care came to approximately $3,500 for a single child; day treatment costs $8,000, residential placement, $22,239, and hospitalization of a child in a state facility, $26,085.

Shunted Children

The needs of individual children should be but are not taken into consideration. For example, a homicidal boy was placed at Spofford Hall, a state training school, after a murder and also because he had attempted suicide. He was refused admission to a psychiatric hospital, because he was not considered "psychotic". This boy has been sent to a State training school that presently -- no matter what the future plans for these services may be -- does not have the required psychiatric facilities for serving him.

A 14-year-old boy with an I.Q. of 65 and a history of setting fires is also currently languishing in a shelter. He, too, was in a State training school and attempted suicide.

Hospitalization was tried and failed, since he also was not considered "psychotic". He now requires placement, but no voluntary agency in child care and no State hospital will accept him because they all feel they cannot meet his needs.

Another boy, recently in the newspapers, attempted murder when he pushed an aged man on to the train tracks of the New York subway at a time when he had run away from a state psychiatric hospital. He was returned there, but Creedmore soon declared him "non-psychotic." At this point, he cannot be helped in any of the open settings of child care, nor will any hospitals admit him. He requires a closed setting, but none exists that will accept him. These are some of the acute problems that face us in the children's field.

These children, for whom no other resources are available have been victimized by a state hospital system that fails to provide the long-term care that they need in its zeal to achieve rapid turnover of the patient load. We grant that short-term care can be very valuable for many children and that institutionalization should be a last resort. But we do insist that there are children for whom this will not do and who drift inevitably into detention shelters, training schools, or into hopelessness.

We would be more ready to agree with the state ideologues if it could be demonstrated that steps are being

taken to provide meaningful alternatives for care of troubled children outside the institution and the hospital.

ARTFUL DODGING OF ALTERNATIVES

Our experience indicates that it is easier to propose than to dispose.

An example of this is our continued failure to develop a comprehensive group home program. There are a great many children who could benefit from living in group apartments or single family home units, where they would receive care, treatment, and education in the community itself. This is a sound alternative to institutionalization and could be an optimal form of care for a large group of children. The mental health profession has endorsed the concept; public officials find it attractive (perhaps because it promises to be less costly than other forms of care); and families of troubled children find it more palatable because it does not carry the stigma of institutionalization.

The movement towards the development of such facilities has faltered, however, because while everyone wants them, they want them someplace else and not in their own backyards.[8] Local zoning boards worry about property

values and local boards of education[9] are reluctant to take on the education of youngsters with psychological problems and educational deficits. The state does not want the children in hospitals; the community wants them out of sight and out of mind. Where do the children go?

We can anticipate that the crisis in child care will become increasingly political. Class action suits and legislative efforts both have taken on political overtones, and while some, such as the Alabama "right to treatment" case, have had positive and dramatic effects in identifying service needs, too frequently these have resulted in new laws rather than new services, to the detriment of the children.

Sadly, the rights of children must seem to come into conflict with the rights of community. In New York City, for example, where the task of finding services for all the children who need help is enormous, there has been a general effort to grant local communities the right to make decisions affecting developments within those communities. Thus, the City of New York, almost adopted a law (#964 in the New York City Charter Review Committee)[10], that would have mandated community board approval for construction, alteration,

or maintenance of new or existing structures used to house three or more abandoned, neglected, or mentally disturbed children, in foster home or agency care, where the cost of care is provided in part out of City funds. While the political goal in this instance has been to authenticate community control groups and establish their right to run their own neighborhoods, the effect has been to exclude minority group children, specifically children with behavior problems for whom group home placement in the community was deemed the most appropriate form of care.

The law thus served to protect real estate interests, rather than children. It should be noted that it took a great effort on the part of the professional community to defeat another proposal, the so-called "cluster" ruling.[11] This ruling sought to prevent agencies from placing group homes side by side so as to avoid the appearance and effects of institutionalization. The prohibition against "cluster" would serve only to harden the attitudes of local communities, inhospitable already to problem children, and would certainly be an obstacle to the further development of the group home concept.

Politicalization dogs every effort to help the minority group child. These are children who would benefit substantially from good prenursery and day care services.

All of our research and experience of child development support the notion that discontinuity of mothering in very early childhood effects subsequent cognitive and emotional development. Family disorganization and family pathology, whether the cause is socio-economic, cultural or emotional in origin, does not contribute to child-rearing practices in a positive way. It is not surprising that some of these terribly deprived children become impulse-ridden and disturbed adolescents for whom our mental health science, at this stage, has few answers. Efforts to give these children the kind of very early care that their parents cannot provide, such as provided at Harlem Hospital by Margaret Lawrence[12] is, unfortunately, resented or resisted as an assault on the family structure, which for political reasons must be defended. It is short sighted to reject help for any reason, if it hurts the children.

OTHER CHILD WELFARE "BOOBY TRAPS"

The Social Security Supplemental Income Plan has been hailed as a tremendous boon to the disabled, for they can now receive help without recourse to public assistance procedures.

Regretfully, as applied to children in foster care by New York City and New York State, the plan's purpose is not so much to help children, but to relieve the city and state of a major proportion of the cost of their care. For the Jewish Board of Guardians is required to complete forms for every child considered eligible for such aid. A criteria check list covers a whole range of disabilities, from mild to severe, including symptoms such as the inability to play with other children and school phobias. Thus, children with even minimal or transient behavioral disorders will be promptly tagged as "disabled".

Labeling a child "disabled" on a social security record victimizes! It also violates confidentiality. And, frankly, can one or should one trust a system that maintains such dossiers on children?

There are further concerns. First of all, a period of treatment should be an episode in the life of a child. Afterwards, the child should return to his place in society. To so label a child in a permanent record for the main purpose of Federal reimbursement is a gross disservice to the child. Furthermore none of the Federal funds find their way into better services but merely replace state and city funds.

When a child lives at home, the decision to apply for social security supplemental income rests with the family. But when the child is placed in an agency, institution, or in foster care, there is no such option. The agency does not have to consult the family, and does not have to secure their consent. In fact, agencies are asked to subvert the rights of both the child and his family by submitting such information to local Departments of Social Services.

THE NO-INCENTIVE WORK SYSTEM

Several years ago, when the war on poverty looked as if it were a fight against the poor, there was an attempt by the Federal government to conduct a pilot program in New York State as a test of a major reform in the welfare system. This was known as the "Work Incentive System". Theoretically, this reform should have motivated welfare families to find their way out of their economic trap. The approach was global, going beyond job finding and training to encompass child care, child welfare and child education.

Because of the character of the program it soon became identified as the "Brownie Point" System. For the incentive was actually a misnomer; it really became a demerit system. If, for example, an adolescent child did not attend

school on a regular basis, the family lost welfare "credits" and actual dollars. Pressure was put on parents to make sure that their children went to school. This system could put a potent weapon in the hands of adolescents who were already in conflict with their families. Not surprisingly the program received short shrift in New York.

SYSTEM's MISANALYSIS

In New York State, there has been a good deal of concern about children who, it is felt, are kept in foster placement for too long because of inadequacies or negligence on the part of child care agencies. It has been alleged that many children could be freed for adoption and given permanent homes, if only the agencies were more efficient. Sensational incidents of child abuse also came to light because of the failure of some public and private agencies to review their foster home placements regularly. The result was legislation requiring regular 24-month reviews by the family court of all children in placement.[12] This, on the face of it, is a sound procedure for the protection of children, and the rights of parents as well.

However, one cannot develop a sound procedure in one part of the system without taking into account the total system. The court calendar is already two years

behind schedule and is overloaded with cases. If there is no time to hear them, what about the regular 24-month review. They have a mighty fine opportunity never to be heard. This is an effort on behalf of children that is not likely to occur. Nonetheless, this effort has had an unforeseen negative -- really disastrous -- consequence.

For in order to deal with the enormous volume of cases, civil court judges have been appointed to hear child care cases. They are not knowledgeable about the family court, about children and the law, child welfare or mental health. They must perforce deal with deeply disturbed children and families arbitrarily and cursorily. They do not recognize or understand the ambivalence of many of the parents, but see them only as families that do not wish to accept their responsibilities and should be made to do so. Thus, many children, in this effort at child advocacy, are sent back to homes where they do not want to be and where they are frequently not wanted. To eliminate one abuse, we have created the possibility of another abuse.

CULTURAL CHANGE AND STRUCTURAL LAG

Perhaps another way in which children are victimized stems from broad cultural changes that are still in the process of becoming.

Cultural anthropologists, notably Parsons and Erikson,[14] have noted that cultural changes occur far in advance of any changes in the social structure. We are living in a society in transition, what with the women's liberation movement, welfare rights developments, the changing role of women in the working world, the development of single parent families, the rise in divorce rates, and the greater economic independence as well as responsibility of women. While supporting and encouraging women in this effort, our society has not taken the structural steps necessary to further support such conceptual changes in life styles. Not only do we lack a system of universal care of children that would make such a life style viable, but also what resources have been developed have been generally limited almost entirely to special-purpose nursery facilities for high-risk minority group children and children of working mothers.

There is still the old commitment to care of the child by the natural mothers exclusively for the first years of life and within their own homes. This generally has not been true of the poor or the rich, and we are sending

women back to work in ever increasing numbers while their children are still very young.

However, we have not as yet provided, as other societies have, the kind of caretaker person to whom the children's rearing can be entrusted. Without such properly trained personnel, one does not create the appropriate structural support for the new life styles. On the one hand, we glorify motherhood and the mothering role, while on the other hand, and simultaneously, we degrade motherhood -- parenthood as well -- by failing to develop appropriate mother or father surrogates. Even worse, we relegate those who do the vital job of parent's surrogate to the class of domestics. The role of the child caretaker is today rather like that of the composer in Mozart's or Haydn's day. They were prized but also relegated to the servant's hall. It was not until Beethoven that the composer came into his own as a creative artist. Perhaps what the child care professional needs is a Beethoven to help upgrade the nature of their creative contribution and thus lift their present oppressive lot.

POSEYS AGAINST THE PLAGUE

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The English social psychiatrist Griffith Edwards once characterized certain alcoholism programs as being as

effective as "poseys against the plague." Some of our efforts are not dissimilar.

It is not too long ago since our friends in government circles were advising mental health professionals to go to court and to use the legislative lobby to effect changes in mental health programs. We were urged to become political activists, to influence our legislators; to become lobbyists on behalf of mental health. In retrospect, it seems that this was probably very good advice at the time.

But the resulting legislation has led to one dispiriting cul-de-sac after another -- or worse, the opposite effect from the one desired was ultimately achieved. Thus, old systems have been discarded, but new systems are still lacking.

Perhaps this is a time to call a moratorium on our legislative activities and our rushing off to court. We need to search for service solutions. After all, laws merely establish our rights to certain mental health programs: They don't produce programs and what exists now constitutes something of a vacuum in program balance.

We seem to be depending upon legislative action or judicial decisions as a solution to problems that cry out

for service solutions.

Admittedly we have a long way to go to reduce the victimization of the child in our society. But definite starts have been made. Child advocacy is a social force whose time has come.

It took a crusading TV reporter to expose the morass and degradation of New York State's Willowbrook and from that came a spate of proposals for small group care facilities for the retarded to provide more dignified care and rehabilitative possibilities. Yet, there is still a gap between proposal and implementation.

It is here where the child advocacy groups can press for a service solution. It needs no legislation, it needs only action on behalf of the victims.

SLIDE 1. CHILDREN AS NONPERSONS

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*There were 3-1/4 million live births in 1972, a 9% drop from 1971

*U.S. ranks 13th in the world in its infant mortality rate. In 1972, the infant mortality rate was 18.2 per 1,000 live births; the range: from 11.0 among advantaged to 41.7 among disadvantaged

*5% of the nation's school age children are not enrolled in schools

*Child labor continues: In Maine, 35% of the potato crop was hand-harvested by children

*There are no special provisions for the children of working mothers, even though there are 6 million children under the age of 6 with working mothers

*3 of every 10 marriages now end in divorce. Yet, there is little professional help available to single parents

*The National Committee to Abolish Corporal Punishment in Schools was founded in ... 1972!

*Only Chicago, New York City, Philadelphia, Pittsburgh, and Baltimore have statutes forbidding the hitting of children by teachers

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SLIDE 2. THE CHILD AS VICTIM OF ABUSE

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EACH YEAR:

*at least 700 children die at the hands of abusive parents

*60,000 children are abused or wilfully neglected

*10,000 are so severely maltreated they require hospitalization

*10% of all children admitted to N. Y. C. hospitals for emergency care have been abused or battered

*250,000 to 350,000 children are in need of protective services according to the American Public Welfare Association

*In more than 500 cases, 80% of families were reunited without any recurrence of abuse, according to Dr. C. Henry Kempe

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SLIDE 3. MENTAL HEALTH FACTS ABOUT CHILDREN

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PSYCHIATRIC CARE:

52,000 in community mental health centers
33,000 in public and private mental hospitals
26,000 in residential treatment centers
526,000 in psychiatric outpatient clinics
millions more are going without help (NIMH)

* Of 2,300 MH clinics in 1968, somewhat less than one-tenth were child guidance clinics
* Only 40% of the 268,000 patients under 18 years seen at such clinics were actually treated, the remaining 60% receiving no more than a diagnosis
* A large proportion of all counties in the U. S. are without mental health clinics altogether
* During the past 2 decades the suicide rate among adolescents and young adults has increased 60%

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Source NIMH 1971

SLIDE 4. CHEMICAL WARFARE AGAINST CHILDREN

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*200,000 MBD children in the U. S. are now being given amphetamines and stimulant therapy

*100,000 receive tranquilizers and antidepressants

*30% of ghetto children are candidates for this therapy or from 4 to 6 million of the general grammar school population, according to the Journal of Learning Disability

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SLIDE 5. CHILDREN AS CONVICTS

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*More than 1,000,000 children in the nation will spend at least a day in an adult jail this year

In 1969, nearly 1,000,000 children, aged 10 to 17, were brought before juvenile courts

*Nearly 500,000 children will be confined in juvenile detention facilities

*Although some are accused of major felonies, a large proportion are held for status offenses, such as truancy, running away from home, or other acts that are not illegal if an adult commits them

*40 to 50% of cases in custody pending dispositional by judges consisted of delinquents who had committed no crimes

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FOOTNOTES

1 Joint Commission on Mental Health, Report of, Crisis In Child Mental Health, Challenge for the 70's (New York: Harper and Row Publishers, 1969).

2 see appendix

3 HR1 - Comprehensive Child Care Bill, vetoed by President Nixon 12/71.

4 Urie Bronfenbrenner, Two Worlds of Childhood, U.S. And U.S.S.R. (New York: Russell Sage Foundation, 1970).

5 Chapter 996 of the laws of 1973, Sections 358 a to b and 398a are part of the New York State Family Court Act, which became effective 9/1/73.

6 Murray Schumach, "Mental Care Is Called Revolving Door," New York Times, March 18, 1974.

7 Legislative Commission on Expenditure Review, Community Mental Health Services (Legislature of the State of New York, Program Audit 5.1.73, October 10, 1973), Chapter VI, p. 47.

8 S.4331-B, introduced by Senator Padavan of the Social Services Committee, would prohibit the location of agency boarding homes or group homes for children in single family residential zones as established by local ordinances and building codes. Introduced but not passed in 1973, it was carried over into the 1974 legislative session.

9 S.9115, introduced by Senator Schermerhorn, stipulates that the placement of children in group homes as defined by Department of Social Service shall be based upon the ability

of the local school district to absorb such children. No group home would be able to place any students in any school districts when such placement would cause the total number of out-of-district students to exceed 3% of the total student population. The bill has been reintroduced in the 1974 legislative session.

10

#964 in the N.Y.C. Charter Review Committee was introduced by Senator Troy, and not passed. It would have required community board approval for erection, alteration or maintenance of any new or existing structure intended to house three or more abandoned, neglected or mentally disturbed children by any foster parent or agency when the cost for care of such children is contributed to in any part by city funds.

11

The so-called "cluster" ruling proposal was a policy adopted by the State Board of Welfare at its April 10, 1973 meeting. No legislation resulted due to the opposition of child care agencies throughout New York.

12

M.M. Lawrence, "Nature, Nurture and Noxia (Trauma) in a Black Community," Presented to the annual meeting of the American Association for the Advancement of Science, San Francisco, February 1974.

also

M.M. Lawrence, Young Inner City Families, the Identification and Development of Ego Strengths Under Stress (New York: Behaviorial Publications, 1974).

13

Section 392 of the New York State Social Services Law was sponsored by Senator Padovian. It requires 24 month reviews by the Family Courts of all children in placement.

14 see especially Erik H. Erikson, Identity, Youth and Crisis (New York: W.W. Norton and Company, Inc., 1968).
also Talcott Parsons, Politics and Social Structure (New York: The Free Press, 1969).

15 Griffith Edwards, "The Chronic Drunkeness Offender: A Therapeutic Alternative To Repeated Imprisonment," February 1965.

. for Youth Bill of Rights

NEW YORK DIVISION FOR YOUTH BILL OF RIGHTS FOR JUVENILES

In recognition of the fact that juveniles residing in Division for Youth facilities have certain basic rights which are not lost or made negotiable by the fact of their institutionalization, the Division here in commences listing specific inalienable rights applicable to all children in our care.

Dress Code

(a) Students have the right to wear their personal clothing if they so choose, or wear combinations of their own clothing and clothing issued by the Division in cases where their own clothing does not meet all of their clothing needs.

(b) Clothing issued by the Division shall be available to those children lacking personal clothing or who choose to wear issued clothing.

(c) Students have the right to wear items of jewelry.

(d) Students may be prohibited from possessing items of clothing or jewelry which could be utilized in such a way as to endanger themselves or others; however, such restrictions are to be reasonable.

(e) Students have the obligation to follow the same criteria of cleanliness for their own clothing as is required for issued clothing, and any student who violates his obligation, may lose his right to wear the item or items of personal clothing not kept in a clean condition.

(f) The Division has the obligation to provide students with reasonable means of cleaning their personal clothing.

(g) Development of self-esteem and individuality through interest in appearance and grooming is to be encouraged.

Personal Appearance

(a) HAIR STYLE-Restrictions on the right of students to determine the length and style of their hair is prohibited, except in individual cases where such restrictions are necessary for reasons of health.

(b) FACIAL HAIR-Restrictions on the right of students to grow facial hair are prohibited, except in individual cases where such restrictions are necessary for reasons of health.

(c) HEALTH AND SAFETY PRECAUTIONS-Students may be required to observe reasonable precautions where the length and style of their hair could possibly pose a health or safety problem unless said precautions are taken.

(d) PRIOR APPROVAL-Where the involuntary removal of a student's hair is determined advisable for reasons of health, the superintendent or director of the facility involved shall make a written request to the facility's middle manager, with a copy to the facility's ombudsman, stating the reasons necessitating such removal and shall not proceed until approval for such action is received.

Religious Freedom

(a) The Division has the obligation to afford its students the right to participate in the religious observances of their parent's faith.

(b) Counseling to members of their faith by authorized representatives of religious denominations is permissible at all Division facilities.

(c) The use of physical force, punishment or coercion to compel attendance or participation in religious observances is prohibited.

Mail Censorship

(a) A student has the unrestricted right to send mail without prior censorship or prior reading.

(b) A student has the right to receive mail without prior reading or prior censorship; however, if the institution suspects the delivery of contraband or cash, it may require the student to open the mail in the presence of a staff member.

(c) A student has the right to mail a minimum of one letter per week at State expense and any number of additional letters at his own expense.

(d) All cash sent to students shall be given to the student or held for his benefit in accordance with the procedures of the institution, however, such procedures shall be in writing and approved by the director of his designee.

(e) Packages are exempt from these provisions and are subject to inspection.

In addition to the Bill of Rights for Juveniles, New York DFY has initiated the following protections of resident rights:

1. A parole revocation procedure under which the child is, entitled to an attorney and an independent hearing officer from outside the agency.

2. A central office review board that monitors all requests for transferrring children from open training schools, to the two security centers.

3. "Stringent controls on the use of room confinement, as well as physical and medical restraints. This has resulted in drastic reduction in the utilization of room confinement."

4. Establishment of medical review board to provide guidelines for medical care and improvement in procedures and controls in the administration of medication for psychiatric reasons.

Related to both the Bill of Rights for Juveniles and the state-wide policies cited above, the DFY has also developed a set of statutory requirements for its facilities. These requirements are addressed to the discipline of children including the use of confinement and medication.

Section 168.1 Discipline of children.

(a) Abuse of children in any form, including corporal punishment, is prohibited.

(b) Deprivation of meals, mail and family visits as methods of punishment, is prohibited.

(c) A child may not be punished for failing or refusing to eat.

(d) Punishment, control and discipline of children shall be an adult responsibility and shall not be prescribed or administered by children.

(e) Every school and center shall submit its discipline policies and any amendments thereto in writing to the director of the division for youth or his designee for approval prior to implementation.

(f) Notice in writing of any violations of the above mentioned regulations (a-d) shall be immediately reported by the facility superintendent or director to the director of the divison for youth or his designee.

Section 168.2 Standards relating to the use of room confinement.

(a) Definition of room confinement. For the purpose of this Part, the term room confinement shall mean confinement of a child in a room, including the child's own room, where locked or when the child is authoritatively told not to leave.

(b) Room confinement shall not be used as a punishment. It shall be used only in cases where a child constitutes a serious and evident danger to himself or others. It is not to be considered, in itself, as a method or technique of treatment.

(c) Place of confinement-environmental needs. Places of confinement within the institution shall be designated by the institution superintendent (or director) and approved by the director of the division for youth or his designee. The place of confinement shall be lighted, heated and ventilated the same as other comparable living areas in the institution.

(d) Required furniture and furnishings within the place of confinement. The place of confinement shall be furnished with the items necessary for the health and comfort of the occupant, including but not limited to, a bed, chair, desk or chest, mattress, pillow, sheet and blanket. If the possession of any of these items would be detrimental to the safety of the occupant or others, they may be removed during that period upon authorization by the superintendent (or director) or the acting superintendent (or director).

(e) Authorization of room confinement. Room confinement shall be authorized only by the superintendent (or director) or the acting superintendent (or director). Authorization should be obtained prior to actual placement in room confinement. In instances where immediate physical restraint is clearly necessary, authorization must be obtained within 15 minutes of lock-up.

(f) Maximum period of confinement. The maximum period of confinement shall not exceed 24 consecutive hours without the approval of the director of the division for youth or designee within the bureau.

(g) Visitation. For the purpose of this Part, a visit shall mean actual entry into the room of confinement with the child or removal of the child from the room of confinement for the purpose of discussion or counseling. A visit shall not include routine visual checks or discussion through the door or window of the confinement room. Children in room confinement shall be visited at least once each day by the following institutional personnel:

(1) Administrative staff - a person at least at the level of senior youth parole worker, assistant director of cottage program or higher.

(Continued on Page 6)

NEW YORK DIVISION FOR YOUTH FIRST TO HAVE BILL OF RIGHTS

(Continued from Page 5)

(2) Clinical staff - psychiatrist, psychologist, social worker.

(3) Medical staff - a nurse or physician shall examine the child in room confinement on a daily basis.

A record of visits shall be maintained by the school (or center) on forms designated by the division and shall be posted on the door of the confinement room during the entire period of confinement.

(h) Reading materials. Educational and recreational reading materials shall be provided within the first 24 hours unless the superintendent (or director) or acting superintendent (or director) shall determine that such materials shall be detrimental to the child's rehabilitation. These materials shall be provided on a daily basis thereafter.

(i) Recreation and exercise. For the purpose of this Part, recreation and exercise shall be defined as an activity taking place outside the room of confinement and shall mean to include, sports, athletics, games, light physical exercise and like activities. It shall not include hard labor, unduly arduous exercise and other activities of a generally unpleasant or punishing nature. Recreation and exercise shall be provided on a daily basis for at least one prescribed period of not less than 30 minutes unless the superintendent (or director) or acting superintendent (or director) shall authorize its deletion upon determination that such a liberty would present a serious and evident danger to the child or others.

(j) Reports of room confinement. Schools and centers must report each instance of room confinement, lasting more than one (1) hour, on forms designated by the Division. Every instance where physical or medical restraints are used shall be reported on these forms, regardless of the length of time of the subsequent confinement. Reports are to be submitted on a weekly basis to the director of the bureau of children's institutional services. For the purpose of this Part, a week begins on a Monday and ends on a Sunday. Reports are to be submitted on or before Tuesday of the following week. A copy of each report shall be sent to the ombudsman assigned to that institution.

(k) Consecutive periods of room confinement.

(1) Any student who is returned to room confinement within six hours of his release shall be considered to have been in continuous room confinement for purposes of reporting and seeking central office approval; however, a notation as to unsuccessful efforts to return the student to program should be made so that an accurate description of the confinement is available.

(2) Return to room confinement after a lapse of six hours from the time of release shall be considered as commencing a new period of room confinement for the purpose of reporting and seeking central office approval.

(3) Manipulation of consecutive periods of room confinement to evade reporting and approval requirements, or to evade the spirit of the division's regulations, is prohibited.

Review and request for extension of room confinement. A review of the necessity for continued room confinement shall be made prior to the beginning of each new 24 hour period by the superintendent (or director) or acting superintendent (or director). Room confinement may be extended beyond the 24 hours only with the approval of the director of the division for youth or designee. Approval shall be obtained prior to the beginning of each 24 hour period. Initially, such requests may be made orally (by telephone). The request must then be submitted in writing on forms designated by the division. This written request must be forwarded to the director of the division for youth or his designee within 24 hours of the oral request.

Every effort shall be made to return the child to the regular program of care as quickly as possible.

Section 168.3 Use of physical and medical restraints.

(a) Physical restraints. Physical restraints shall be used only in cases where a child is uncontrollable and constitutes a serious and evident danger to himself or others. They shall be removed as soon as the child is no longer uncontrollable. If restraints are placed on a child's hands and feet, the hand and foot restraints are not to be joined, as for example, in hog tying. When in restraints, a child may be attached to any furniture or fixture in the room. Nothing in this section shall preclude the use of restraints in the transportation of a child from one institution to another.

(b) Medical restraint. For the purposes of these regulations, medical restraint shall mean medication administered either by injection or orally for the purposes of quieting an uncontrollable child.

(1) Medical restraint shall be administered only in situations where a child is so uncontrollable that no other means of restraint can prevent the child from harming himself.

(2) Medical restraint shall be authorized only by a physician and be administered only by approved personnel.

(c) Reporting requirements. Use of physical and medical restraints shall be reported, pursuant to Section 168.2, paragraph (j).

Section 168.4 Group Confinement.

(a) Group confinement shall be constructed to include situations where a child is separated from the general population and normal daily program by confinement in a locked cottage or living unit.

(b) Group confinement shall not be used as punishment. It shall be used only in cases where a child constitutes a serious and evident danger to himself or others, is himself in serious and evident danger, or demonstrates by his own behavior or by his own expressed desire, that he is in need of special care and attention in a living unit separate from his normal surroundings.

(c) Each institution wishing to institute a group confinement program must submit a detailed description of the program, including regulations governing its administration to the director of the division for youth for approval.

(d) Each institution administering an approved group confinement program shall maintain a daily log indicating the number of children in group confinement and their period of stay in the program. This information shall be forwarded to the director or his designee monthly.

(e) The ombudsman for each institution administering an approved group confinement program shall have access to the daily log and the confinement area. It shall be his responsibility to report any deviation from the approved program to the institution's superintendent or director and, in an appropriate case, he may include documented deviations in his ombudsman's reports.

(f) Where institutions instituted group confinement programs prior to the adoption of these regulations, they shall submit detailed written program description and regulations to the director of the division for youth within thirty days from receipt of notice of adoption of these regulations. Any institution failing to have an approved program within 60 days of the adoption of these regulations, shall terminate the use of group confinement.

(g) Program description, regulations and amendments governing each approved group confinement program shall be kept on file at the institution and in the Albany Central Office.

(h) Changes in group confinement programs and regulations shall be approved in the same manner as the initial program was approved.

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training schools to eliminate the co-mingling of juvenile delinquents (JDs) and persons in need of supervision.

The state's highest court, ruling on an individual case and reversing a lower court